2016 Medical Plan Options Comparison of Benefit Coverages

	Anthem Blue Cross Plus	Anthem Blue Cross PPO	Anthem Blue Cross Core Value	Anthem Blue Cross EPO Exclusive	Anthem Blue Cross HDHP	Kaiser
Member services	1-866-641-1689	1-866-641-1689	1-866-641-1689	1-866-641-1689	1-866-641-1689	1-800-464-4000
Web site	www.anthem.com/ca/llns/	www.anthem.com/ca/llns/	www.anthem.com/ca/llns/	www.anthem.com/ca/llns/	www.anthem.com/ca/llns/	http://my.kp.org/llns
HSA Funding	N/A	N/A	$750 Individual; $1,500 Family	N/A	$750 Individual; $1,500 Family	N/A
Annual deductible: Individual/Family	In Network - $300 Individual; $900 Family	In Network - $500 Individual; $1,500 Family	In Network - $3,000 Individual; $6,000 Family; combined in/out-of-network; no coverage paid for any single member unless $3,000 deductible is met, or $6,000 as a family	$0 Individual; $0 Family	In Network - $1,500 Individual; $3,000 Family; no coverage paid for any member of a family unless $3,000 deductible is met	$0 Individual; $0 Family
	Out of Network - $500 Individual; $1,500 Family	Out of Network - $1,000 Individual; $3,000 Family	Out of Network - $3,000 Individual; $6,000 Family; combined in/out-of-network; no coverage paid for any single member unless $3,000 deductible is met, or $6,000 as a family	No coverage Out-of-Network	Out of Network - $3,000 Individual; $6,000 Family; no coverage for any member of a family unless $6,000 deductible is met	No coverage Out-of-Network
Coinsurance percentage	In Network - 80% covered until out-of-pocket maximum is met	In Network - 80% covered until out-of-pocket maximum is met	In Network - 80% covered until out-of-pocket maximum is met	90% covered	In Network - 90% covered until out-of-pocket maximum is met	100% covered
	Out of Network - 60% covered; subject to Reasonable and Customary limits until out-of-pocket maximum is met	Out of Network - 60% covered until out-of-pocket maximum is met; subject to Reasonable and Customary limits	Out of Network - 60% covered until out-of-pocket maximum is met; subject to Reasonable and Customary limits	No coverage Out-of-Network	Out of Network - 70% covered until out-of-pocket maximum is met; subject to Reasonable and Customary limits	No coverage Out-of-Network
Out-of-pocket maximum: Individual/Family	In Network - $2,500 Individual; $7,500 Family; in & out-of-network maximums are exclusive of each other; includes deductible and copays	In Network - $3,000 Individual; $9,000 Family; in & out-of-network maximums are exclusive of each other; includes deductible	In Network - $5,000 Individual; $10,000 Family; in & out-of-network maximums are exclusive of each other; includes deductible and Rx maximum allowed amount	$1,000 Individual; $3,000 Family; includes copays	In Network - $3,000 Individual; $6,000 Family; in & out-of-network maximums are exclusive of each other; includes deductible and Rx maximum allowed amount	$1,500 Individual; $3,000 Family; copays included; excluding durable medical equipment, prescription drugs and infertility services
	Out of Network - $7,000 Individual; $21,000 Family; in & out-of-network maximums are exclusive of each other; includes deductible and copays	Out of Network - $6,000 Individual; $18,000 Family; in & out-of-network maximums are exclusive of each other; includes deductible	Out of Network - $10,000 Individual; $20,000 Family; in & out-of-network maximums are exclusive of each other; includes deductible and Rx maximum allowed amount	No coverage Out-of-Network	Out of Network - $6,000 Individual; $12,000 Family; in & out-of-network maximums are exclusive of each other; includes deductible and Rx maximum allowed amount	No coverage Out-of-Network
Lifetime coverage limit	In Network - Limit does not apply	In Network - Limit does not apply	In Network - Limit does not apply	Limit does not apply	In Network - Limit does not apply	Limit does not apply
	Out of Network - Limit does not apply	Out of Network - Limit does not apply	Out of Network - Limit does not apply	No coverage Out-of-Network	Out of Network - Limit does not apply	No coverage Out-of-Network
Need to file claims	In-Network: No	In-Network: No	In-Network: No	Not Applicable	In-Network: No	No (In-Network)
	Out-of-Network: Yes	Out-of-Network: Yes	Out-of-Network: Yes		Out-of-Network: Yes	Required only for Emergency Services received outside of Kaiser Permanente
Ability to self-refer to OB/GYN	Yes	Yes	Yes	Yes	Yes	Yes
				No coverage Out-of-Network		No coverage Out-of-Network

NOTE: If there is a discrepancy between the benefits as described in this chart and the plan administrator's system, the plan administrator's system governs for determining benefit coverage.

2016 Medical Plan Options Comparison of Benefit Coverages

	Anthem Blue Cross Plus	Anthem Blue Cross PPO	Anthem Blue Cross Core Value	Anthem Blue Cross EPO Exclusive	Anthem Blue Cross HDHP	Kaiser
Ability to self-refer to specialists	Yes	Yes	Yes	Yes	Yes	Check with your guidebook to see if your facility has departments that don't require a referral
				No coverage Out-of-Network		No coverage Out-of-Network
Out-of-area dependent coverage	Yes	Yes	Yes	Yes	Yes	Refer to disclosure form and evidence of coverage for details
Out-of-area participant coverage	Yes	Yes	Yes	Yes	Yes	Refer to disclosure form and evidence of coverage for details
Primary doctor office visit	In Network - $25 copay	In Network - 80% covered after deductible is met	In Network - 80% covered after deductible is met	$25 copay	In Network - 90% covered after deductible is met	$25 copay
	Out of Network - 60% covered; after deductible is met; subject to Reasonable and Customary limits	Out of Network - 60% covered after deductible is met; subject to Reasonable and Customary limits	Out of Network - 60% covered after deductible is met; subject to Reasonable and Customary limits	No coverage Out-of-Network	Out of Network - 70% covered after deductible is met; subject to Reasonable and Customary limits	No coverage Out-of-Network
Specialist office visit	In Network - $35 copay	In Network - 80% covered after deductible is met	In Network - 80% covered after deductible is met	$35 copay	In Network - 90% covered after deductible is met	$25 copay
	Out of Network - 60% covered; after deductible is met; subject to Reasonable and Customary limits	Out of Network - 60% covered after deductible is met; subject to Reasonable and Customary limits	Out of Network - 60% covered after deductible is met; subject to Reasonable and Customary limits	No coverage Out-of-Network	Out of Network - 70% covered after deductible is met; subject to Reasonable and Customary limits	No coverage Out-of-Network
Annual physical exam	In Network - 100% covered	In Network - 100% covered	In Network - 100% covered	100% covered	In Network - 100% covered	100% covered; for preventive
	Out of Network - 60% covered; after deductible is met; subject to Reasonable and Customary limits	Out of Network - 60% covered; subject to Reasonable and Customary limits	Out of Network - 60% covered after deductible is met; subject to Reasonable and Customary limits	No coverage Out-of-Network	Out of Network - 70% covered after deductible is met; subject to Reasonable and Customary limits	No coverage Out-of-Network
Well-woman exam (includes pap)	In Network - 100% covered for preventive care	In Network - 100% covered for preventive care	In Network - 100% covered for preventive care	100% covered for preventive care	In Network - 100% covered for preventive care	100% covered for preventive care
	Out of Network - 60% covered; after deductible is met; subject to Reasonable and Customary limits	Out of Network - 60% covered after deductible is met; subject to Reasonable and Customary limits	Out of Network - 60% covered after deductible is met; subject to Reasonable and Customary limits	No coverage Out-of-Network	Out of Network - 70% covered after deductible is met; subject to Reasonable and Customary limits	No coverage Out-of-Network
Mammogram	In Network - Diagnostic: 80% covered after deductible is met; 100% covered for preventive care	In Network - Diagnostic: 80% covered after deductible is met; 100% covered for preventive care	In Network - Diagnostic: 80% covered after deductible is met; 100% covered for preventive care	Diagnostic: 90% covered; 100% covered for preventive care	In Network - Diagnostic: 90% covered after deductible is met; 100% covered for preventive care	100% covered for preventive care
	Out of Network - 60% covered; after deductible is met; subject to Reasonable and Customary limits	Out of Network - 60% covered after deductible is met; subject to Reasonable and Customary limits	Out of Network - 60% covered after deductible is met; subject to Reasonable and Customary limits	No coverage Out-of-Network	Out of Network - 70% covered after deductible is met; subject to Reasonable and Customary limits	No coverage Out-of-Network
	In Network - 100% covered for preventive care	In Network - 100% covered for preventive care	In Network - 100% covered for preventive care	100% covered for preventive care	In Network - 100% covered for preventive care	100% covered for preventive care

NOTE: If there is a discrepancy between the benefits as described in this chart and the plan administrator's system, the plan administrator's system governs for determining benefit coverage.

2016 Medical Plan Options Comparison of Benefit Coverages						
	Anthem Blue Cross Plus	**Anthem Blue Cross PPO**	**Anthem Blue Cross Core Value**	**Anthem Blue Cross EPO Exclusive**	**Anthem Blue Cross HDHP**	**Kaiser**
Immunizations (child)	Out of Network - 60% covered; after deductible is met; subject to Reasonable and Customary limits	Out of Network - 60% covered after deductible is met; subject to Reasonable and Customary limits	Out of Network - 60% covered after deductible is met; subject to Reasonable and Customary limits	No coverage Out-of-Network	Out of Network - 70% covered after deductible is met; subject to Reasonable and Customary limits	No coverage Out-of-Network

NOTE: If there is a discrepancy between the benefits as described in this chart and the plan administrator's system, the plan administrator's system governs for determining benefit coverage.

2016 Medical Plan Options Comparison of Benefit Coverages

	Anthem Blue Cross Plus	Anthem Blue Cross PPO	Anthem Blue Cross Core Value	Anthem Blue Cross EPO Exclusive	Anthem Blue Cross HDHP	Kaiser
Cancer screenings	In Network - 100% covered for preventive care; diagnostic: covered as any other illness; for Cancer Clinical Trials refer to EOC/SPD	In Network - 100% covered for preventive care; diagnostic: covered as any other illness; for Cancer Clinical Trials refer to EOC/SPD	In Network - 100% covered for preventive care; diagnostic: covered as any other illness; for Cancer Clinical Trials refer to EOC/SPD	100% covered for preventive care; diagnostic: covered as any other illness; for Cancer Clinical Trials refer to EOC/SPD	In-Network: 100% covered for preventive care; diagnostic: covered as any other illness, for Cancer Clinical Trials refer to EOC/SPD	100% covered
	Out of Network - Covered as any other illness; for Cancer Clinical Trials refer to EOC/SPD	Out of Network - Covered as any other illness; for Cancer Clinical Trials refer to EOC/SPD	Out of Network - Covered as any other illness; for Cancer Clinical Trials refer to EOC/SPD	No coverage Out-of-Network	Out-of-Network: Covered as any other illness; for Cancer Clinical Trials refer to ECO/SPD	No coverage Out-of-Network
Cardiovascular screenings	Covered under Medical or Routine Physical exam as appropriate					100% covered; no coverage Out-of-Network
Allergy tests and treatments	In Network - Diagnostic test/diagnostic treatment: $25 copay PCP, $35 copay Specialist; allergy injections 100% covered	In Network - Diagnostic test/diagnostic treatment: 80% covered after deductible is met; allergy injections 100% covered	In Network - Diagnostic test/diagnostic treatment: 80% covered after deductible is met	Diagnostic test/diagnostic treatment: $25 copay PCP, $35 copay Specialist; allergy injections 100% covered	In Network - Diagnostic test/diagnostic treatment: 90% covered after deductible is met	Diagnostic and testing: $25 copay per visit, allergy injections: $5 copay per visit
	Out of Network - Diagnostic test/diagnostic treatment: 60% covered; after deductible is met; subject to Reasonable and Customary limits	Out of Network - Diagnostic test/diagnostic treatment: 60% covered after deductible is met; subject to Reasonable and Customary limits	Out of Network - Diagnostic test/diagnostic treatment: 60% covered after deductible is met; subject to Reasonable and Customary limits	No coverage Out-of-Network	Out of Network - Diagnostic test/diagnostic treatment: 70% covered after deductible is met; subject to Reasonable and Customary limits	No coverage Out-of-Network
Outpatient surgery	In Network - 80% covered after deductible is met	In Network - 80% covered after deductible is met	In Network - 80% covered after deductible is met	90% covered	In Network - 90% covered after deductible is met	$100 copay; per procedure
	Out of Network - 60% covered; after deductible is met; subject to Reasonable and Customary limits	Out of Network - 60% covered after deductible is met; subject to Reasonable and Customary limits	Out of Network - 60% covered after deductible is met; subject to Reasonable and Customary limits; benefit limited to $350/visit	No coverage Out-of-Network	Out of Network - 70% covered after deductible is met; subject to Reasonable and Customary limits	No coverage Out-of-Network
Outpatient laboratory services	In Network - 80% covered after deductible is met	In Network - 80% covered after deductible is met	In Network - 80% covered after deductible is met	90% covered	In Network - 90% covered after deductible is met	100% covered
	Out of Network - 60% covered; after deductible is met; subject to Reasonable and Customary limits	Out of Network - 60% covered after deductible is met; subject to Reasonable and Customary limits	Out of Network - 60% covered after deductible is met; subject to Reasonable and Customary limits	No coverage Out-of-Network	Out of Network - 70% covered after deductible is met; subject to Reasonable and Customary limits	No coverage Out-of-Network
Outpatient X-ray	In Network - 80% covered after deductible is met	In Network - 80% covered after deductible is met	In Network - 80% covered after deductible is met	90% covered	In Network - 90% covered after deductible is met	100% covered
	Out of Network - 60% covered; after deductible is met; subject to Reasonable and Customary limits	Out of Network - 60% covered after deductible is met; subject to Reasonable and Customary limits	Out of Network - 60% covered after deductible is met; subject to Reasonable and Customary limits	No coverage Out-of-Network	Out of Network - 70% covered after deductible is met; subject to Reasonable and Customary limits	No coverage Out-of-Network

NOTE: If there is a discrepancy between the benefits as described in this chart and the plan administrator's system, the plan administrator's system governs for determining benefit coverage.

2016 Medical Plan Options Comparison of Benefit Coverages

	Anthem Blue Cross Plus	Anthem Blue Cross PPO	Anthem Blue Cross Core Value	Anthem Blue Cross EPO Exclusive	Anthem Blue Cross HDHP	Kaiser
Outpatient physical therapy	In Network - $25 copay; limited to 25 visits per year; combined in-network and out-of-network; additional visits available if necessary after medical review	In Network - 80% covered after deductible is met; limited to 25 visits per year; combined in-network and out-of-network; additional visits available if necessary after medical review	In Network - 80% covered after deductible is met; limited to 25 visits per year; combined in-network and out-of-network; additional visits available if necessary after medical review	$25 copay; limited to 25 visits per year; additional visits available if necessary after medical review	In Network - 90% covered after deductible is met; limited to 25 visits per year; combined in-network and out-of-network; additional visits available if necessary after medical review	$25 copay; per visit
	Out of Network - 60% covered after deductible is met; limited to 25 visits per year; combined in-network and out-of-network; additional visits available if necessary after medical review; subject to R&C limits	Out of Network - 60% covered after deductible is met; limited to 25 visits per year; combined in-network and out-of-network; additional visits available if necessary after medical review; subject to R&C limits	Out of Network - 60% cov. after deductible; limited to 25 visits/year; combined in-network and out-of-network; additional visits available if necessary after medical review; subject to R&C limits; benefit limited to $25/visit	No coverage Out-of-Network	Out of Network - 70% covered after deductible is met; limited to 25 visits per year; combined in-network and out-of-network; additional visits available if necessary after medical review; subject to R&C limits	No coverage Out-of-Network
Outpatient occupational therapy	In Network - $25 copay; limited to 25 visits per year; combined in-network and out-of-network; additional visits available if necessary after medical review	In Network - 80% covered after deductible is met; limited to 25 visits per year; combined in-network and out-of-network; additional visits available if necessary after medical review	In Network - 80% covered after deductible is met; limited to 25 visits per year; combined in-network and out-of-network; additional visits available if necessary after medical review	$25 copay; limited to 25 visits per year; additional visits available if necessary after medical review	In Network - 90% covered after deductible is met; limited to 25 visits per year; combined in-network and out-of-network; additional visits available if necessary after medical review	$25 copay; per visit
	Out of Network - 60% covered after deductible is met; limited to 25 visits per year; combined in-network and out-of-network; additional visits available if necessary after medical review; subject to R&C limits	Out of Network - 60% covered after deductible is met; limited to 25 visits per year; combined in-network and out-of-network; additional visits available if necessary after medical review; subject to R&C limits	Out of Network - 60% cov. after deductible; limited to 25 visits/year; combined in-network and out-of-network; additional visits available if necessary after medical review; subject to R&C limits; benefit limited to $25/visit	No coverage Out-of-Network	Out of Network - 70% covered after deductible is met; limited to 25 visits per year; combined in-network and out-of-network; additional visits available if necessary after medical review; subject to R&C limits	No coverage Out-of-Network
Outpatient speech therapy	In Network - $25 copay; limited to 25 visits per year; combined in-network and out-of-network; additional visits available if necessary after medical review	In Network - 80% covered after deductible is met; limited to 25 visits per year; combined in-network and out-of-network; additional visits available if necessary after medical review	In Network - 80% covered after deductible is met; limited to 25 visits per year; combined in-network and out-of-network; additional visits available if necessary after medical review	$25 copay; limited to 25 visits per year; additional visits available if necessary after medical review	In Network - 90% covered after deductible is met; limited to 25 visits per year; combined in-network and out-of-network; additional visits available if necessary after medical review	$25 copay; per visit
	Out of Network - 60% covered after deductible is met; limited to 25 visits per year; combined in-network and out-of-network; additional visits available if necessary after medical review; subject to R&C limits	Out of Network - 60% covered after deductible is met; limited to 25 visits per year; combined in-network and out-of-network; additional visits available if necessary after medical review; subject to R&C limits	Out of Network - 60% cov. after deductible; limited to 25 visits/year; combined in-network and out-of-network; additional visits available if necessary after medical review; subject to R&C limits; benefit limited to $25/visit	No coverage Out-of-Network	Out of Network - 70% covered after deductible is met; limited to 25 visits per year; combined in-network and out-of-network; additional visits available if necessary after medical review; subject to R&C limits	No coverage Out-of-Network
Office visit:	In Network - $25 copay initial visit only	In Network - 80% covered; deductible waived	In Network - 80% covered after deductible is met	$25 copay initial visit only	In Network - 90% covered; deductible waived	100% covered

NOTE: If there is a discrepancy between the benefits as described in this chart and the plan administrator's system, the plan administrator's system governs for determining benefit coverage.

2016 Medical Plan Options Comparison of Benefit Coverages

	Anthem Blue Cross Plus	Anthem Blue Cross PPO	Anthem Blue Cross Core Value	Anthem Blue Cross EPO Exclusive	Anthem Blue Cross HDHP	Kaiser
Office visit: Pre/postnatal	Out of Network - 60% covered; after deductible is met; subject to Reasonable and Customary limits	Out of Network - 60% covered after deductible is met; subject to Reasonable and Customary limits	Out of Network - 60% covered after deductible is met; subject to Reasonable and Customary limits	No coverage Out-of-Network	Out of Network - 70% covered after deductible is met; subject to Reasonable and Customary limits	No coverage Out-of-Network

NOTE: If there is a discrepancy between the benefits as described in this chart and the plan administrator's system, the plan administrator's system governs for determining benefit coverage.

2016 Medical Plan Options Comparison of Benefit Coverages

	Anthem Blue Cross Plus	Anthem Blue Cross PPO	Anthem Blue Cross Core Value	Anthem Blue Cross EPO Exclusive	Anthem Blue Cross HDHP	Kaiser
In-hospital delivery services	In Network - $250 copay; 80% covered thereafter; $200 penalty if nonemergency services are not preauthorized	In Network - 80% covered after deductible is met; $200 penalty if nonemergency services are not preauthorized	In Network - 80% covered; after plan deductible	$250 copay; per occurrence or admittance; 90% covered thereafter; $200 penalty if nonemergency services are not preauthorized	In Network - 90% covered after deductible is met	$500 copay; per admission
	Out of Network - 60% covered; after deductible is met; $200 penalty if nonemergency services are not preauthorized; subject to Reasonable and Customary limits	Out of Network - 60% covered after deductible is met; $200 penalty if nonemergency services are not preauthorized; subject to Reasonable and Customary limits	Out of Network - 60% covered; after plan deductible; subject to Reasonable and Customary limits	No coverage Out-of-Network	Out of Network - 70% covered after deductible is met; subject to Reasonable and Customary limits	No coverage Out-of-Network
Newborn nursery services	In Network - 80% covered after deductible is met	In Network - 80% covered after deductible is met	In Network - 80% covered after deductible is met	90% covered	In Network - 90% covered after deductible is met	100% covered for outpatient; $500 copay per inpatient admission
	Out of Network - 60% covered; after deductible is met; subject to Reasonable and Customary limits	Out of Network - 60% covered after deductible is met; subject to Reasonable and Customary limits	Out of Network - 60% covered after deductible is met; subject to Reasonable and Customary limits	No coverage Out-of-Network	Out of Network - 70% covered after deductible is met; subject to Reasonable and Customary limits	No coverage Out-of-Network
Pediatric exams	In Network - 100% covered for preventive care; well-child visit includes hearing and eye exam through age 6	In Network - 100% covered for preventive care; well-child visit includes hearing and eye exam through age 6	In Network - 100% covered for preventive care; well-child visit includes hearing and eye exam through age 6	100% covered for preventive care; well-child visit includes hearing and eye exam through age 6	In Network - 100% covered for preventive care; well-child visit includes hearing and eye exam through age 6	100% covered for preventive care; well-child visits 100% covered up to 23 months
	Out of Network - 60% covered; after deductible is met; subject to Reasonable and Customary limits	Out of Network - 100% covered after deductible is met; birth thru age six; 60% covered age seven and older; subject to Reasonable and Customary limits	Out of Network - 60% covered after deductible is met; subject to Reasonable and Customary limits	No coverage Out-of-Network	Out of Network - 70% covered after deductible is met; subject to Reasonable and Customary limits	No coverage Out-of-Network
Fertility services	In Network only - 50% covered; $20,000 lifetime maximum for all infertility benefits combined; medical and pharmacy	Not covered	Not covered	In Network only - 50% covered; $20,000 lifetime maximum for all infertility benefits combined; medical and pharmacy	Not covered	Covered at 50% member rate; for diagnosis and treatment of involuntary infertility when approved by a Plan physician
In vitro fertilization	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Artificial insemination	In Network only - 50% covered; $20,000 lifetime maximum for all infertility benefits combined; medical and pharmacy	Not covered	Not covered	In Network only - 50% covered; office visit copay applies; $20,000 lifetime maximum for all infertility benefits combined; medical and pharmacy	Not covered	Covered at 50% member rate (intrauterine only); except for donor semen and donor eggs and services related to their procurement and storage
Female tubal ligation	In Network - Check with Plan; 100% covered under expanded preventive care coverage for women	In Network - Check with Plan; 100% covered under expanded preventive care coverage for women	In Network - Check with Plan; 100% covered under expanded preventive care coverage for women	In Network: Check with Plan; 100% covered under expanded preventive care coverage for women	In-Network: Check with Plan; 100% covered under expanded preventive care coverage for women	100% covered under expanded preventive care coverage for women; after appropriate counseling

NOTE: If there is a discrepancy between the benefits as described in this chart and the plan administrator's system, the plan administrator's system governs for determining benefit coverage.

2016 Medical Plan Options Comparison of Benefit Coverages

	Anthem Blue Cross Plus	Anthem Blue Cross PPO	Anthem Blue Cross Core Value	Anthem Blue Cross EPO Exclusive	Anthem Blue Cross HDHP	Kaiser
[illegible]	Out of Network - 60% covered; after deductible is met; subject to Reasonable and Customary limits	Out of Network - 60% covered; subject to Reasonable and Customary limits	Out of Network - 60% covered; subject to reasonable and Customary limits	No coverage Out-of-Network	Out-of-Network: 70% of C&R covered after deductible is met	No coverage Out-of-Network

NOTE: If there is a discrepancy between the benefits as described in this chart and the plan administrator's system, the plan administrator's system governs for determining benefit coverage.

2016 Medical Plan Options Comparison of Benefit Coverages

	Anthem Blue Cross Plus	Anthem Blue Cross PPO	Anthem Blue Cross Core Value	Anthem Blue Cross EPO Exclusive	Anthem Blue Cross HDHP	Kaiser
Male vasectomy	In Network - $75 copay	In Network - 80% covered after deductible is met	In Network - 80% covered after deductible is met	90% covered	In-Network: 90% covered after deductible is met	$25 copay; outpatient; $500 copay inpatient; after appropriate counseling
	Out of Network - 60% covered; after deductible is met; subject to Reasonable and Customary limits	Out of Network - 60% covered; subject to Reasonable and Customary limits	Out of Network - 60% covered; subject to reasonable and Customary limits	No coverage Out-of-Network	Out-of-Network: 70% of C&R after deductible is met	No coverage Out-of-Network
Hearing Exams	In Network - $25 copay PCP; $35 copay Specialist; copay based on place of service and services performed	In Network - 80% covered after deductible is met	In Network - 80% covered after deductible is met	$25 copay PCP; $35 copay Specialist; copay based on place of service and services performed	In Network - 90% covered after deductible is met	100% covered; per exam as needed
	Out of Network - 60% covered; after deductible is met; subject to Reasonable and Customary limits	Out of Network - 60% covered after deductible is met; subject to Reasonable and Customary limits	Out of Network - 60% covered after deductible is met; subject to Reasonable and Customary Limits	No coverage Out-of-Network	Out of Network - 70% covered after deductible is met; subject to Reasonable and Customary limits	No coverage Out-of-Network
Hearing aids	In Network - 50% covered; limited to two hearing aid devices every 36 months; $2,000 benefit maximum; both analog and digital devices	In Network - 50% covered; limited to two hearing aid devices every 36 months, $2,000 benefit maximum; both analog and digital devices	In Network - 80% covered after deductible is met; covered under Durable Medical Equipment; limited to one hearing aid per ear every three years	50% covered; two standard hearing aid devices every 36 months; $2,000 benefit maximum	In Network - 90% covered after deductible is met; limited to two hearing aids every 36 months, both analog and digital devices	$1,000 allowance per aid; every 36 months
	Out of Network - Not covered	Out of Network - Not covered	Out of Network - 60% covered after deductible is met; covered under Durable Medical Equipment; limited to one hearing aid per ear every three years; subject to Reasonable and Customary Limits	No coverage Out-of-Network	Out of Network - 70% covered after deductible is met; limited to two hearing aids every 36 months	No coverage Out-of-Network
Routine vision exams	Not covered	Not covered	Not covered	Not covered	Not covered	Eye exams for refraction: 100% covered
Regular lenses and frames	Not Covered - Except for the first pair of glasses or contacts after medically necessary eye surgery					Not Covered
Contact lenses						Not Covered
Accidental injury to teeth	In- or Out-of-Network: Emergency services only; check with Plan for other covered benefits	In- or Out-of-Network: Emergency services only; check with Plan for other covered benefits	In- or Out-of-Network: Emergency services only; check with Plan for other covered benefits	In- or Out-of-Network - Emergency services only; check with Plan for other covered benefits	In- or Out-of-Network: Emergency services only; check with Plan for other covered benefits	Not covered
Surgical removal of oral tumors, cysts and impacted teeth	Covered under Medical Surgery Benefit	Covered under Medical Surgery Benefit	Covered under Medical Surgery Benefit	Covered under Medical Surgery Benefit	Covered under Medical Surgery Benefit	Tumors and cysts are covered if medically necessary; extractions are covered in preparation for radiation therapy; when deemed necessary by a Plan physician; no coverage Out-of-Network

NOTE: If there is a discrepancy between the benefits as described in this chart and the plan administrator's system, the plan administrator's system governs for determining benefit coverage.

2016 Medical Plan Options Comparison of Benefit Coverages

	Anthem Blue Cross Plus	Anthem Blue Cross PPO	Anthem Blue Cross Core Value	Anthem Blue Cross EPO Exclusive	Anthem Blue Cross HDHP	Kaiser
Hospital copay (Semi-Private Room, medically necessary Intensive Care or Private Room) Includes Facility billed Lab & X-ray	In Network - $250 copay per admission; then 80% covered after plan deductible; $200 penalty if nonemergency services are not preauthorized	In Network - 80% covered; after plan deductible; $200 penalty if nonemergency services are not preauthorized	In Network - 80% covered; after plan deductible	$250 copay per admission; then 90% covered; $200 penalty if nonemergency services are not preauthorized	In Network - 90% covered; after plan deductible	$500 copay per admission
	Out of Network - 60% covered; after plan deductible; $200 penalty if nonemergency services are not preauthorized; subject to Reasonable and Customary limits	Out of Network - 60% covered; after plan deductible; $200 penalty if nonemergency services are not preauthorized; subject to Reasonable and Customary limits	Out of Network - 60% covered; after plan deductible; subject to Reasonable and Customary limits	No coverage Out-of-Network	Out of Network - 70% covered; after plan deductible; subject to Reasonable and Customary limits	No coverage Out-of-Network
Inpatient physician and surgeon services	In Network - 80% covered after hospital copay/deductible	In Network - 80% covered after plan deductible	In Network - 80% covered after plan deductible	90% covered after hospital copay/deductible	In Network - 90% covered after plan deductible	100% covered after hospital copay/deductible
	Out of Network - 60% covered after plan deductible; subject to Reasonable and Customary limits	Out of Network - 60% covered after plan deductible; subject to Reasonable and Customary limits	Out of Network - 60% covered after plan deductible; subject to Reasonable and Customary limits	No coverage Out-of-Network	Out of Network - 70% covered after plan deductible; subject to Reasonable and Customary limits	No coverage Out-of-Network
Emergency room (not followed by admission)	In Network - $100 copay; then 80% covered after deductible is met; waived if admitted	In Network - 80% covered after deductible is met	In Network - 80% covered after deductible is met	In-Network: $100 copay; then 90% covered; waived if admitted	In Network - 90% covered after deductible is met	$100 copay; waived if admitted
	Out of Network - $100 copay; waived if admitted	Out of Network - 80% covered after deductible is met	Out of Network - 80% covered after deductible is met; non-emergencies subject to Reasonable and Customary limits	Out-of-Network: $100 copay for emergencies; waived if admitted	Out of Network - 90% covered after deductible is met	$100 copay; waived if admitted
Urgent care clinic visit	In Network - $25 copay	In Network - 80% covered after deductible is met	In Network - 80% covered after deductible is met	$25 copay	In Network - 90% covered after deductible is met	$25 copay; per visit
	Out of Network - 60% covered; after deductible is met; subject to Reasonable and Customary limits	Out of Network - 60% covered after deductible is met; subject to Reasonable and Customary limits	Out of Network - 60% covered after deductible is met; subject to Reasonable and Customary limits	No coverage Out-of-Network	Out of Network - 70% covered after deductible is met; subject to Reasonable and Customary limits	$25 copay; per visit; non-Plan providers covered when outside the service area
Ambulance services	In Network - 80% covered after deductible is met; subject to medical necessity	In Network - 80% covered after deductible is met; must be medically necessary	In Network - 80% covered after deductible is met; must be medically necessary	In Network - 90% covered; must be medically necessary	In Network - 90% covered after deductible is met; must be medically necessary	$50 copay per trip
	Out of Network - 60% covered; no copay if true emergency; must be medically necessary; subject to Reasonable and Customary limits	Out of Network - 60% covered; must be medically necessary; subject to Reasonable and Customary limits	Out of Network - 80% covered; must be medically necessary; subject to Reasonable and Customary limits	Out of Network - 90% covered; must be medically necessary; subject to Reasonable and Customary limits	Out of Network - 70% covered; must be medically necessary; subject to Reasonable and Customary limits	
Annual prescription deductible	Not applicable	Not applicable	Medical deductible applies; member pays 100% of the Rx cost until medical deductible is met	Not applicable	Medical deductible applies; member pays 100% of the Rx cost until medical deductible is met	Not applicable
Prescription drug Web site	www.caremark.com	www.caremark.com	www.caremark.com	www.caremark.com	www.caremark.com	www.kaiserpermanente.org

NOTE: If there is a discrepancy between the benefits as described in this chart and the plan administrator's system, the plan administrator's system governs for determining benefit coverage.

2016 Medical Plan Options Comparison of Benefit Coverages

	Anthem Blue Cross Plus	Anthem Blue Cross PPO	Anthem Blue Cross Core Value	Anthem Blue Cross EPO Exclusive	Anthem Blue Cross HDHP	Kaiser
Prescription drug member services	1-866-623-1438	1-866-623-1438	1-866-623-1438	1-866-623-1438	1-866-623-1438	1-800-464-4000
Prescription benefits are covered under medical deductible	No	No	Yes	No	Yes	Not applicable
Prescription drug vendor	Caremark	Caremark	Caremark	Caremark	Caremark	Kaiser
Annual Rx Out-of-pocket maximum	$2,800 Individual; $5,700 Family (in-network only)	$2,100 Individual; $4,200 Family (in-network only)	Medical out-of-pocket maximum applies; once medical out-of-pocket maximum is met, Rx is 100% covered for the remainder of the calendar year	$3,500 Individual; $7,000 Family	Medical out-of-pocket maximum applies; once medical deductible is met, Rx is 100% covered for the remainder of the calendar year	Not applicable
Retail generic	In Network - $10 copay; 30 day supply Out of Network - 50% of average whole price schedule plus charges above the schedule	In Network - $10 copay; 30 day supply Out of Network - 50% of average whole price schedule plus charges above the schedule	In Network - 80% covered after deductible is met Out of Network - 60% covered after deductible is met	$10 copay; 30 day supply; Non-participating pharmacies: 50% of average whole price schedule plus charges above the schedule	In Network - 90% covered after deductible is met Out of Network - 70% covered after deductible is met	$10 for up to a 30-day supply; $30 for up to a 100-day supply; at Kaiser Pharmacy; as prescribed by Plan Physician
Retail formulary brand	In Network - 80% covered; $40 minimum copay, $60 maximum copay; 30 day supply Out of Network - 50% of average whole price schedule plus charges above the schedule	In Network - 80% covered; $40 minimum copay, $60 maximum copay; 30 day supply Out of Network - 50% of average whole price schedule plus charges above the schedule	In Network - 80% covered after deductible is met Out of Network - 60% covered after deductible is met	80% covered; $40 minimum copay, $60 maximum copay; 30 day supply; Non-participating pharmacies: 50% of average whole price schedule plus charges above the schedule	In Network - 90% covered after deductible is met Out of Network - 70% covered after deductible is met	$35 for up to a 30-day supply; $105 for up to a 100-day supply; at Kaiser Pharmacy; as prescribed by Plan Physician
Retail nonformulary brand	In Network - 60% covered; $60 minimum copay, $100 maximum copay; 30 day supply Out of Network - 50% of average whole price schedule plus charges above the schedule	In Network - 60% covered; $60 minimum copay, $100 maximum copay; 30 day supply Out of Network - 50% of average whole price schedule plus charges above the schedule	In Network - 80% covered after deductible is met Out of Network - 60% covered after deductible is met	60% covered; $60 minimum copay, $100 maximum copay; 30 day supply; Non-participating pharmacies: 50% of average whole price schedule plus charges above the schedule	In Network - 90% covered after deductible is met Out of Network - 70% covered after deductible is met	$35 for up to a 30-day supply; $105 for up to a 100-day supply; at Kaiser Pharmacy; as prescribed by Plan Physician
Mail order generic	$20 copay; 90 day supply; must use plan mail order facility	$20 copay; 90 day supply; must use plan mail order facility	80% covered after deductible is met	$20 copay; 90 day supply; must use plan mail order facility	90% covered after deductible	$10 for up to a 30-day supply; $20 for up to a 100-day supply; mail order as prescribed by Plan Physician
Mail order formulary brand	80% covered; $80 minimum copay, $120 maximum copay; 90 day supply; must use plan mail order facility	80% covered; $80 minimum copay, $120 maximum copay; 90 day supply; must use plan mail order facility	80% covered after deductible is met	80% covered; $80 minimum copay, $120 maximum copay; 90 day supply; must use plan mail order facility	90% covered after deductible	$35 for up to a 30-day supply; $70 for up to a 100-day supply; mail order as prescribed by Plan Physician
Mail order nonformulary brand	60% covered; $120 minimum copay, $200 maximum copay; 90 day supply; must use plan mail order facility	60% covered; $120 minimum copay, $200 maximum copay; 90 day supply; must use plan mail order facility	80% covered after deductible is met	60% covered; $120 minimum copay, $200 maximum copay; 90 day supply; must use plan mail order facility	90% covered after deductible	$35 for up to a 30-day supply; $70 for up to a 100-day supply; mail order as prescribed by Plan Physician and deemed medically necessary

NOTE: If there is a discrepancy between the benefits as described in this chart and the plan administrator's system, the plan administrator's system governs for determining benefit coverage.

2016 Medical Plan Options Comparison of Benefit Coverages						
	Anthem Blue Cross Plus	**Anthem Blue Cross PPO**	**Anthem Blue Cross Core Value**	**Anthem Blue Cross EPO Exclusive**	**Anthem Blue Cross HDHP**	**Kaiser**
Oral contraceptives	Check with Plan; some contraceptives 100% covered under expanded preventive care coverage for women		Check with Plan; some contraceptives 100% covered under expanded preventive care coverage for women	Check with Plan; some contraceptives 100% covered under expanded preventive care coverage for women	Check with Plan; some contraceptives 100% covered under expanded preventive care coverage for women	100% covered as part of expanded preventive care coverage for women

NOTE: If there is a discrepancy between the benefits as described in this chart and the plan administrator's system, the plan administrator's system governs for determining benefit coverage.

2016 Medical Plan Options Comparison of Benefit Coverages

	Anthem Blue Cross Plus	Anthem Blue Cross PPO	Anthem Blue Cross Core Value	Anthem Blue Cross EPO Exclusive	Anthem Blue Cross HDHP	Kaiser
Fertility drugs	Check with Plan	Check with Plan	Check with Plan	Check with Plan	Check with Plan	50% member rate copay as prescribed by Plan physician
Mental Health: Combined with substance abuse	No	No	No	No	No	No
Mental Health: Outpatient coverage	In-network: $0 copay for visits 1-5; $25 copay for visits 6 and over	In-network: 80% coinsurance	In-network: 80% coinsurance	In-network: $0 copay for visits 1-5; $25 copay for visits 6 and over	In-network: 90% coinsurance	$25 copay individual visit; $12 copay group visit; unlimited visits
	Out-of-network: 60% coinsurance	Out-of-network: 60% coinsurance	Out-of-network: 60% coinsurance	No coverage Out-of-Network	Out-of-network: 70% coinsurance	No coverage Out-of-Network
Mental Health: Inpatient coverage	In-network: 80% coinsurance	In-network: 80% coinsurance	In-network: 80% coinsurance	In-network: 90% coinsurance	In-network: 90% coinsurance	$500 copay per admission
	Out-of-network: 60% coinsurance	Out-of-network: 60% coinsurance	Out-of-network: 60% coinsurance	No coverage Out-of-Network	Out-of-network: 70% coinsurance	No coverage Out-of-Network
Substance Abuse: Outpatient coverage	In-network: $25 copay	In-network: 80% coinsurance	In-network: 80% coinsurance	In-network: $25 copay	In-network: 90% coinsurance	$25 copay individual visit; $5 copay group visit; unlimited visits
	Out-of-network: 60% coinsurance	Out-of-network: 60% coinsurance	Out-of-network: 60% coinsurance	No coverage Out-of-Network	Out-of-network: 70% coinsurance	No coverage Out-of-Network
Substance Abuse: Inpatient coverage	In-network: 80% coinsurance	In-network: 80% coinsurance	In-network: 80% coinsurance	In-network: 90% coinsurance	In-network: 90% coinsurance	$500 copay per admission; $100 copay for transitional residential recovery services; mental health/chemical dependency services accrue to out-of-pocket maximum
	Out-of-network: 60% coinsurance	Out-of-network: 60% coinsurance	Out-of-network: 60% coinsurance	No coverage Out-of-Network	Out-of-network: 70% coinsurance	No coverage Out-of-Network
Chiropractic	In Network - $25 copay; limited to 25 visits per calendar year	In Network - 80% covered after deductible is met; limited to 25 visits per calendar year	In Network - 80% covered after deductible is met; limited to 25 visits per year; combined in-network and out-of-network	$25 copay; limited to 25 visits per calendar year	In Network - 90% covered after deductible is met; limited to 25 visits per calendar year	Member discounts available through American Specialty Health network
	Out of Network - 60% covered; after calendar year deductible is met; limited to 25 visits per calendar year; subject to Reasonable and Customary limits	Out of Network - 60% covered after deductible is met; limited to 25 visits per calendar year; subject to Reasonable and Customary limits	Out of Network - 60% covered after deductible is met; limited to 25 visits/year; combined in-network and out-of-network; subject to Reasonable and Customary limits; benefit limited to $25 per visit	No coverage Out-of-Network	Out of Network - 70% covered after deductible is met; limited to 25 visits per calendar year; subject to Reasonable and Customary limits	No coverage Out-of-Network

NOTE: If there is a discrepancy between the benefits as described in this chart and the plan administrator's system, the plan administrator's system governs for determining benefit coverage.

2016 Medical Plan Options Comparison of Benefit Coverages

	Anthem Blue Cross Plus	Anthem Blue Cross PPO	Anthem Blue Cross Core Value	Anthem Blue Cross EPO Exclusive	Anthem Blue Cross HDHP	Kaiser
Acupuncture	In Network - $25 copay; limited to 25 visits per calendar year	In Network - 80% covered after deductible is met; limited to 25 visits per calendar year	In Network - 80% covered after deductible is met; limited to 12 visits per calendar year (combined in/out-of-network) and $30 per visit	$25 copay; limited to 25 visits per calendar year	In Network - 90% covered after deductible is met; limited to 25 visits per calendar year	Member discounts available
	Out of Network - 60% covered; after calendar year deductible is met; limited to 25 visits per calendar year; subject to Reasonable and Customary limits	Out of Network - 60% covered after deductible is met; limited to 25 visits per calendar year; subject to Reasonable and Customary limits	Out of Network - 60% covered after deductible is met; limited to 12 visits per calendar year (combined in/out-of-network) and $30 per visit; subject to Reasonable and Customary limits	No coverage Out-of-Network	Out of Network - 70% covered after deductible is met; limited to 25 visits per calendar year; subject to Reasonable and Customary limits	No coverage Out-of-Network
Heart disease care management	Not applicable (treatment of the disease is covered)					Covered; check website for details
Hypertension care management						Covered; check website for details
Diabetes care management						Covered; check website for details
Asthma care management						Covered; check website for details
Prenatal care management						Covered; check website for details
Cancer care management						Covered; check website for details
Smoking cessation program	Not covered					Covered; check website for details
Weight control program	Not covered except for treatment of Anorexia Nervosa or Bulimia Nervosa (See Mental Nervous Benefit)	Not covered except for treatment of Anorexia Nervosa or Bulimia Nervosa (See Mental Nervous Benefit)	Not covered except for treatment of Anorexia Nervosa or Bulimia Nervosa (See Mental Nervous Benefit)	Not covered except for treatment of Anorexia Nervosa or Bulimia Nervosa (See Mental Nervous Benefit)	Not covered except for treatment of Anorexia Nervosa or Bulimia Nervosa (See Mental Nervous Benefit)	Covered; check website for details
Noncustodial home health care	In Network - 80% covered after deductible is met; limited to 100 visits per calendar year; combined in-network and out-of-network; maximum 4 hours per visit	In Network - 80% covered after deductible is met; limited to 100 visits per calendar year; combined in-network and out-of-network; maximum 4 hours per visit	In Network - 80% covered after deductible is met; limited to 100 visits per calendar year; combined in-network and out-of-network; maximum 4 hours per visit	90% covered; limited to 100 visits per calendar year; maximum 4 hours per visit	In Network - 90% covered after deductible is met; limited to 100 visits per calendar year; combined in-network and out-of-network; maximum 4 hours per visit	100% covered; up to 100 visits per calendar year
	Out of Network - 60% covered after deductible is met; limited to 100 visits per calendar year; combined in-network and out-of-network; maximum 4 hours per visit; subject to Reasonable and Customary limits	Out of Network - 60% covered after deductible is met; limited to 100 visits per calendar year; combined in-network and out-of-network; maximum 4 hours per visit; subject to Reasonable and Customary limit	Out of Network - 60% covered after deductible is met; limited to 100 visits per calendar year; combined in-network and out-of-network; maximum 4 hours per visit; subject to Reasonable and Customary limits	No coverage Out-of-Network	Out of Network - 70% covered after deductible is met; limited to 100 visits per calendar year; combined in-network and out-of-network; maximum 4 hours per visit; subject to Reasonable and Customary limit	No coverage Out-of-Network

NOTE: If there is a discrepancy between the benefits as described in this chart and the plan administrator's system, the plan administrator's system governs for determining benefit coverage.

2016 Medical Plan Options Comparison of Benefit Coverages

	Anthem Blue Cross Plus	Anthem Blue Cross PPO	Anthem Blue Cross Core Value	Anthem Blue Cross EPO Exclusive	Anthem Blue Cross HDHP	Kaiser
Hospice care	In Network - 80% covered after deductible is met; as authorized by Anthem Blue Cross Case Management; limitations may apply	In Network - 80% covered after deductible is met; as authorized by Anthem Blue Cross Case Management; limitations may apply	In Network - 80% covered after deductible is met; limitations may apply	90% covered; as authorized by Anthem Blue Cross Case Management; limitations may apply	In-Network: 70% covered after deductible is met as authorized by Anthem Blue Cross Case Management; limitations may apply	100% covered when prescribed by Plan Physician
	Out of Network - 60% covered after deductible is met; as authorized by Anthem Blue Cross Case Management; subject to R&C limits; limitations may apply	Out of Network - 80% covered after deductible is met; as authorized by Anthem Blue Cross Case Management; subject to R&C limits; limitations may apply	Out of Network - 80% covered after deductible is met; subject to Reasonable and Customary limits; limitations may apply	No coverage Out-of-Network	Out-of-Network: 90% covered after deductible is met as authorized by Anthem Blue Cross Case Management; subject to C&R limits; limitations may apply	No coverage Out-of-Network
Prescribed care in noncustodial skilled nursing facility	In Network - 80% covered after deductible is met; limited to 240 days per calendar year; combined in-network and out-of-network	In Network - 80% covered after deductible is met; limited to 240 days per calendar year; combined in-network and out-of-network	In Network - 80% covered after deductible is met; limited to 100 days per calendar year; combined in-network and out-of-network	90% covered; limited to 240 days per calendar year	In Network - 90% covered after deductible is met; limited to 240 days per calendar year; combined in-network and out-of-network	100% covered; up to 100 days per benefit period; when prescribed by Plan Physician
	Out of Network - 60% covered after deductible is met; limited to 240 days per calendar year; combined in-network and out-of-network; subject to Reasonable and Customary limits	Out of Network - 60% covered after deductible is met; limited to 240 days per calendar year; combined in-network and out-of-network; subject to Reasonable and Customary limits	Out of Network - 60% covered after deductible is met; limited to 100 days per calendar year; combined in-network and out-of-network; subject to Reasonable and Customary limits	No coverage Out-of-Network	Out of Network - 70% covered after deductible is met; limited to 240 days per calendar year; combined in-network and out-of-network; subject to Reasonable and Customary limits	No coverage Out-of-Network
Durable medical equipment	In Network - 80% covered after deductible is met; subject to utilization review	In Network - 80% covered after deductible is met; subject to utilization review	In Network - 80% covered after deductible is met; subject to utilization review	90% covered; subject to utilization review	In Network - 90% covered after deductible is met; subject to utilization review	100% covered; formulary
	Out of Network - 60% covered; subject to Reasonable and Customary limits; subject to utilization review	Out of Network - 60% covered after deductible is met; subject to Reasonable and Customary limits; subject to utilization review	Out of Network - 60% covered after deductible is met; subject to utilization review; subject to Reasonable and Customary limits	No coverage Out-of-Network	Out of Network - 70% covered after deductible is met; subject to Reasonable and Customary limits; subject to utilization review	No coverage Out-of-Network

C&R = customary and reasonable

NOTE: If there is a discrepancy between the benefits as described in this chart and the plan administrator's system, the plan administrator's system governs for determining benefit coverage.